

UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2014
QUALITY IMPROVEMENT INCENTIVE (2)(iv) APPLICATION
Patient Life Enhancing Devices, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2014

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has purchased or enhanced patient life enhancing devices, which must be one or more of the following:
- ☐ Telecommunication enhancements primarily for patient use. This may include land lines, wireless telephones, voice mail and push to talk devices. Overhead paging, if any, must be reduced.
 - ☐ Wander management systems and patient security enhancement devices (e.g. cameras, access control systems, access doors, etc.)
 - ☐ Computers and game consoles for patient use (includes TVs)
 - ☐ Garden enhancements
 - ☐ Furniture enhancements for patients (includes mattresses, bed spreads, comforters but not blankets or sheets)
 - ☐ Wheelchair washers
 - ☐ Automatic doors
 - ☐ Flooring enhancements
 - ☐ Automatic Electronic Defibrillators (AED devices)
 - ☐ Energy efficient windows with a U-factor rating of 0.35 or less
 - ☐ Exercise equipment for group fitness classes (e.g., weights, exercise balls, exercise bikes, etc.)
- ☐ A detailed description of the patient life enhancing devices is attached.
- ☐ The patient life enhancing devices were purchased by May 31, 2014.
- ☐ The patient life enhancing devices were installed between July 1, 2012 and May 31, 2014.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to \$495 per Medicaid Certified bed under this incentive (count as at 7/1/2013). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is \$580.18 per Medicaid Certified bed (count as at 7/1/2013). Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): \$ _____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>

For Medicaid use only:

Amount reimbursed

Maximum per-bed payout:

Date Paid